[redacted]
[redacted]
[redacted] **MI** [redacted]

Date Mailed: October 16, 2019
MOAHR Docket No.: 19-007606
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Lynn M. Ferris

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 42 CFR 431.200 to 431.250. After due notice, a telephone hearing was held on August 15, 2019, from [redacted] Michigan. The Petitioner was represented by herself. The Department of Health and Human Services (Department) was represented by Marci Walker, Lead Worker.

During the hearing, Petitioner waived the time period for the issuance of this decision in order to allow for the submission of additional records. The records from Dr. [redacted] including the DHS-49 and the last six months of treatment records and a complete list of MRIs were received and marked into evidence as Exhibit B. The record closed on September 16, 2019; and the matter is now before the undersigned for a final determination based on the evidence presented.

ISSUE

Did the Department properly determine that Petitioner was not disabled for purposes of the State Disability Assistance (SDA) benefit program?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On February 22, 2019, Petitioner submitted an application seeking cash assistance on the basis of a disability.

2. On June 28, 2019, the Disability Determination Service (DDS)/Medical Review Team (MRT) found Petitioner not disabled for purposes of the SDA program.

3. On July 1, 2018, the Department sent Petitioner a Notice of Case Action denying the application based on DDS/MRT's finding of no disability.

4. On July 12, 2019, the Department received Petitioner's timely written request for hearing.

5. Petitioner alleged disabling impairment due to her lumbar spine, thoracic spine and cervical spine causing disabling pain due to spinal stenosis, lumbar region with neurogenic claudication, anterolisthesis, and spondylolisthesis of the lumbar region.

6. The Petitioner has alleged no mental impairment affecting her ability to work.

7. On the date of the hearing, Petitioner was [redacted] years old with an [redacted] birth date; she is [redacted] in height and weighs about [redacted] pounds. Petitioner testified that she recently lost 50 pounds due to a bariatric sleeve procedure.

8. Petitioner is *a high school graduate* with one and a half years of college.

9. At the time of application, Petitioner was not employed.

10. Petitioner has an employment history of working as a Certified Nurse Assistant, a Convenience Store Clerk/Cashier, a cashier for [redacted], a Home Health Care Provider, and working at [redacted] taking orders and stocking supplies.

11. Petitioner has a pending disability claim with the Social Security Administration.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), and Department of Human Services Reference Tables Manual (RFT).

The State Disability Assistance (SDA) program, which provides financial assistance for disabled persons, was established by 2004 PA 344. The Department administers the SDA program pursuant to 42 CFR 435, MCL 400.10 *et seq.* and Mich Admin Code, Rules 400.3151 – 400.3180.

Petitioner applied for cash assistance alleging a disability. A disabled person is eligible for SDA. BEM 261 (July 2015), p. 1. An individual automatically qualifies as disabled for purposes of the SDA program if the individual receives Supplemental Security Income (SSI) or Medical Assistance (MA-P) benefits based on disability or blindness. BEM 261, p. 2. Otherwise, to be considered disabled for SDA purposes, a person must have a physical or mental impairment for at least ninety days which meets federal SSI disability standards, meaning the person is unable to do any substantial gainful activity

by reason of any medically determinable physical or mental impairment. BEM 261, pp. 1-2; 20 CFR 416.901; 20 CFR 416.905(a).

Determining whether an individual is disabled for Supplemental Security Income (SSI) purposes requires the application of a five-step evaluation of whether the individual (1) is engaged in substantial gainful activity (SGA); (2) has an impairment that is severe; (3) has an impairment and duration that meet or equal a listed impairment in Appendix 1 Subpart P of 20 CFR 404; (4) has the residual functional capacity to perform past relevant work; and (5) has the residual functional capacity and vocational factors (based on age, education and work experience) to adjust to other work. 20 CFR 416.920(a)(1) and (4); 20 CFR 416.945. If an individual is found disabled, or not disabled, at any step in this process, a determination or decision is made with no need to evaluate subsequent steps. 20 CFR 416.920(a)(4). If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4).

In general, the individual has the responsibility to establish a disability through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-related activities or, if a mental disability is alleged, to reason and make appropriate mental adjustments. 20 CFR 416.912(a); 20 CFR 416.913. An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a). Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, are insufficient to establish disability. 20 CFR 416.927(d).

Step 1

The first step in determining whether an individual is disabled requires consideration of the individual's current work activity. 20 CFR 416.920(a)(4)(i). If an individual is working and the work is SGA, then the individual must be considered not disabled, regardless of medical condition, age, education, or work experience. 20 CFR 416.920(b); 20 CFR 416.971. SGA means work that involves doing significant and productive physical or mental duties and that is done, or intended to be done, for pay or profit. 20 CFR 416.972.

In this case, Petitioner was not working during the period for which assistance might be available. Because Petitioner was not engaged in SGA, she is not ineligible under Step 1; and the analysis continues to Step 2.

Step 2

Under Step 2, the severity and duration of an individual's alleged impairment is considered. If the individual does not have a severe medically determinable physical or mental impairment (or a combination of impairments) that meets the duration requirement, the individual is not disabled. 20 CFR 416.920(a)(4)(ii). The duration requirement for SDA means that the impairment is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 90 days. 20 CFR 416.922; BEM 261, p. 2.

An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities. 20 CFR 416.920(a)(4)(ii); 20 CFR 416.920(c). Basic work activities mean the abilities and aptitudes necessary to do most jobs, such as (i) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (ii) the capacity to see, hear, and speak; (iii) the ability to understand, carry out, and remember simple instructions; (iv) use of judgment; (v) responding appropriately to supervision, co-workers and usual work situations; and (vi) dealing with changes in a routine work setting. 20 CFR 416.921(b). A claim may be denied at Step 2 only if the evidence shows that the individual's impairments, when considered in combination, do not have more than a minimal effect on the person's physical or mental ability to perform basic work activities. Social Security Ruling (SSR) 85-28.

The individual bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. While the Step 2 severity requirement may be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint, under the *de minimis* standard applied at Step 2, an impairment is severe unless it is only a slight abnormality that minimally affects work ability regardless of age, education and experience. *Higgs v Bowen,* 880 F2d 860, 862-863 (CA 6, 1988), citing *Farris v Sec of Health and Human Services,* 773 F2d 85, 90 n.1 (CA 6, 1985). *Id.;* SSR 96-3p.

The medical evidence presented at the hearing, *and in response to the interim order,* was reviewed and is summarized below.

The Petitioner was seen at Advanced Rheumatology on [redacted] 2018. The Petitioner reported to the office with symptomology of joint pain which was noted as coming on gradually. The severity of the problem at the time was moderate. Pain scale was 6/10. Symptoms were described as constant, and the problem has not changed. Symptoms reported included pain and stiffness. The evaluation was for a new patient for evaluation of joint and muscle pain. During the exam, the patient advised that she was diagnosed with gout and is on Allopurinol. The Petitioner reported a history of fibromyalgia. She has tried Lyrica with no relief. Neurontin was also prescribed without relief. Patient also presents history of lower-back pain and nerve impingement. A neurosurgeon advised her that surgery was not necessary at this point. Patient reported trying injections to her back with no relief. Patient reported pain medications did not help. At the time of the examination, the patient had been approved for bariatric

surgery for the following month. The following x-rays were ordered: foot, hand and sacroiliac joint. A review of systems was also conducted and noted the patient was positive for fatigue, dyspnea and wheezing, nocturia, polydipsia, headache, memory impairment and night sweats, anxiety depression with sleep disturbances, rash and joint pain stiffness, swelling, muscle weakness and myalgia weakness.

A physical examination was also conducted of the cervical spine noting tenderness in the cervical and lumbar spine and the right elbow. There was no pain in the thoracic spine, no tenderness or swelling in the knees, or limitation of motion. Soft tissue discomfort was noted in the right chest, low back, right lateral epicondyle; and there were 4/18 total tender points. The patient's mood was appropriate. At the time of the examination, the Petitioner's body mass index was 60.00-69.9. At the hearing, the Petitioner testified that the rheumatologist ruled out rheumatoid arthritis.

The Medical records contained x-rays of the right and left hands. The impression for the right hand was no significant degenerative changes. The left hand results were the same; both right and left hand noted mild soft tissue swelling.

The Petitioner is regularly seen at [redacted], by Dr. [redacted] who treats her for her lumbar pain. On [redacted] 2018, the Petitioner was seen for a follow-up lumbar MRI. At the time, she advised she was doing fairly well with increasing pain in her low back. The patient further reported her ADLs are difficult due to pain. She complains of pain in her cervical and lumbar spine, as well as intermittent pain in her bilateral legs, felt more on the right side. She has tried and failed physical therapy and injections with no improvement of her pain. At the time of the examination, the pain score was 7/10 with duration at noted as constant. The notes of the examination indicate limited range of motion of the lumbar spine with increased pain upon extension, flexion right or left lateral rotation. No sacroiliac joint tenderness noted. Straight leg raising was negative sitting. The strength in lower extremities in all areas innervated by L2 through S1 is 5/5. Petitioner was able to heel and toe walk. Based on the diagnostic imaging, the impression was lumbar disc herniation with radiculopathy and spondylolisthesis of lumbar region. The notes indicate the doctor was concerned about body mass index, which was reported as over 60. An x-ray of the lumbar spine was ordered.

On [redacted] 2018, the Petitioner was seen for a neurosurgical consultation. At the time of the exam, the Petitioner's BMI was 67.97; and she weighed 396 pounds. There was no palpable cervical or thoracic spinous process tenderness. There was palpable spinous process tenderness noted in the lower back L3-S1. There was no facet tenderness noted. Patient exhibited limited range of motion of the lumbar spine with increased pain upon extension and flexion and with lateral rotation. At the conclusion of the examination, she was to undergo an MRI of the lumbar spine.

The Petitioner underwent an MRI in [redacted] 2019. The MRI noted mild cervical spinal canal narrowing at C4-C5 and C5-C6, with no mass effect on cord. Cervical cord is normal without nerve root impingement seen. Also noted, mild left neural frontal

narrowing at C4-C5, otherwise diffusely patent neural foramina. There was also focal edema on the right at level C2-C-3 with noted probability on the basis of ligamentous strain or injury, which may account for some of the patient's right-sided radicular cervical symptoms. There was no underlying bony abnormality noted on the MRI. An unremarkable thoracic spine MRI also was included. There was no significant thoracic spinal canal or neural foraminal stenosis detected. There were mild thoracic degenerative disc changes noted. In the notes for the cervical spine, there were other small disc bulges at C3 and C4 with no spinal canal or lateral recess narrowing. At C4-C5, there was mild canal stenosis from a small broad-based disc bulge paracentral toward the left. At C5-C6, there was a mild canal stenosis from a right paracentral disc bulge with no narrowing. The MRI of the thoracic spine conclusions were mild scattered degenerative disc disease; no acute fracture or malalignment is seen. No significant spinal canal narrowing; the neural foraminal are diffusely patent.

An earlier MRI of the cervical spine was conducted on [redacted] 2018. The impression was mild progression in the anterior and posterior disc osteophyte complexes from C3 to C7. No significant central canal stenosis. Annual or tear and small posterior disc protrusion at C3-C4, which is new compared to the previous exam (2011) and multilevel bilateral new nerve root irritation due to disc protrusions. The specific notes of the MRI indicate that at C5-C6 there is persistent protrusion towards the right causing right nerve root irritation. The examiner concluded there was nerve root irritation on the left at C6-C7, on the right at C5-C6 and on the left at C4 present due to posterior disc protrusions.

The Petitioner was seen at [redacted] for complaints of chronic pain on [redacted] 2017. At the time she was prescribed Lyrica, the examination by the doctor noted decreased range of motion of the cervical and lumbar spines with diffuse tenderness to palpation the diagnosis noted inter-vertebral disc displacement lumbar region, restless leg syndrome, headache, obstructive sleep apnea and diabetes mellitus with diabetic neuropathy unspecified as well as neck pain on follow-up and reevaluation of multiple ongoing neurological problems. The doctor noted that most of neurological issues were due to fibromyalgia and migraines. She is marbled morbidly obese with multiple associated coal morbidities. She will benefit from bariatric surgery. It will also help her diabetes mellitus, sleep apnea, chronic back pain and headaches. With regard to chronic pain, the doctor believed she was better to follow up at one of the pain clinics; and a referral was made. Due to her increased persistent neck pain, an MRI scan of the cervical spine was ordered. A prescription was also made for restless leg syndrome.

On [redacted] 2018, doctor's notes for the neurological center indicate a referral was made for neurosurgical consult; the EMG results for the upper extremities noted no cervical radiculopathy. The MRI of the cervical spine for [redacted] 2018, noted an annular tear and small posterior disc protrusion at C3-C4, which was new. Also noted was multiple bilateral nerve root irritation due to disc protrusions. The Petitioner was seen again on [redacted] 2018, and was no longer using her walker or wheelchair. At that time, the doctor advised to discontinue Lyrica and any other neuropathic

preventative meds that may contribute to weight gain so that the Petitioner can undergo bariatric surgery and consider pain injections to avoid neuropathic medications that may contribute to weight gain.

The Petitioner is seen by [redacted] for her primary care medical needs. The notes indicate that she has been using a CPAP machine, which has helped to alleviate lack of sleep and improved dress fullness. The notes indicate bronchial asthma is well-controlled with no cough, wheezing or shortness of breath. Her spirometry for [redacted] 2018 was within normal limits. A copy of the pulmonary function test was included and was verified. At the time of the [redacted] 2018, office visit, the impression was bronchial asthma well-controlled, rhinitis well-controlled, Gerd well-controlled; and obstructive sleep apnea improved due to using CPAP machine. The Petitioner testified at the hearing that these conditions were not disabling to her.

At the hearing, the Petitioner also testified that she was recently diagnosed with ovarian cancer and underwent a hysterectomy in [redacted] 2019. The Petitioner is also being tested to determine whether or not the cancer has spread. Her liver has been examined, and cirrhosis of the liver was noted. The condition is not caused by alcohol. No medical records regarding her symptomology or testing of the liver are part of the medical documentation at this time.

The Petitioner was treated at [redacted] and was seen by a dietitian to assist her with weight loss. Although the Petitioner was seen for outpatient therapy due to depression, the Petitioner does not claim mental impairment as a disability.

The Petitioner was seen throughout [redacted] 2018 for weight control counseling and weight checks at the [redacted].

An MRI of the lumbar spine was conducted on [redacted] 2017. It was taken due to low-back pain. At that time, the conclusion was mild degenerative changes seen at L5-S1 level, slightly worse as compared to prior MRI with mild bilateral neural foraminal narrowing seen. Tiny right paracentral disc protrusion seen at T12-L1 level without patent central canal and neural foramina.

The Petitioner's treating doctor, a neurosurgeon, completed a DHS-49 Medical Examination Report on [redacted] 2019. The current diagnosis was cervical neck pain with evidence of disc disease pain throughout cervical, thoracic spine and numbness on left side of her back. The Petitioner's current weight was [redacted] pounds. The doctor attached numerous MRIs and CT scans of the lumbar, thoracic and cervical spine as well as x-ray examinations in support of his evaluation. The clinical impression was the Petitioner was stable. The doctor imposed limitations which included no bending or twisting and that sitting and standing were indicated, as tolerated. The doctor imposed a 10-pound lifting/carrying limit. The doctor also imposed no repetitive motion with regard to operation of foot and leg controls. With respect to Petitioner's ability to stand and sit, the doctor noted sit, stand and lie as tolerated, thus, restricting these activities

due to pain. With respect to whether the Petitioner may need assistance in her home, he indicated she may need assistance with housework. The last six months of medical records were also provided with respect to his treatment of the Petitioner.

The MRI reports attached to the DHS-49 Medical Examination Report are summarized briefly hereafter. On [redacted] 2019, an MRI of the lumbar spine was conducted and compared with a prior MRI taken in 2012. The notable findings were that a 2- to 3-mm anterolisthesis of L5 on S1 is seen. Endplate changes are noted at L5-S1 (low signal on T1 -weighted and high signal on T2 -weighted) consistent with Modic type I changes seen with secondary changes of degenerative disc disease. Otherwise, bone marrow limits within normal limits. The L5-S1 intervertebral disc spaces narrowed with loss of signal on the T2 weighted images consistent with disc desiccation (dehydration). Mild hypertrophy of the L4-5 and L5-S1 facets are noted; the remaining facets are normal. In connection with this MRI, an x-ray study of the lumbar spine was also conducted with regard to spine flexion/extension maneuvers. The impression of the study noted lumbosacral spine flexion/extension maneuvers show L5 on S1 anterolisthesis, L5 on S1, .73 cm with flexion; L5 on S1 neutral, .54 cm and Lumbar spine extension L5 on S1 .34 cm. Lumbosacral spine L5 bilateral pars interarticularis spondylosis fractures. Lumbosacral spine minimal osteopenia; L5-S1 moderate degenerative disc disease. The intervertebral disc spaces demonstrate degenerative disc disease.

An MRI of the cervical spine dated [redacted] 2019, was also attached. The impression was mild cervical spinal canal narrowing at C4-C5 and C5-C6 with no mast effect on cord. Mild left neural frontal narrowing at C4-C5. Focal edema on the right at the level C2-C-3 surrounding the articular pillar, probably on the basis of ligamentous strain or injury which may account for some of the patient's right-sided radicular cervical symptoms. No discrete fracture seen. At C3-C4, there is a small, broad disc bulge without significant spinal canal or lateral recess narrowing. There were small paracentral disc bulges at C4-C5, C5-C6, C6-C7 with no significant canal or neural foraminal narrowing. The results of the MRI of the thoracic spine taken on the same date were unremarkable with no significant thoracic spinal canal or neural foraminal stenosis detected. No significant nerve root compression is seen.

The doctors progress notes were also provided and demonstrate that most recently, beginning [redacted] 2019, the Petitioner has reported increasing back pain even after undergoing bariatric surgery in [redacted] 2018. On [redacted] 2019, Petitioner had reported losing [redacted] pounds since her surgery with no improvement in her back pain. Petitioner complained of constant sharp, dull, heavy, burning, achy, stabbing low-back pain with numbness that radiates into her left hip and buttock. She also described pain down her left leg; and on that date, rated her pain as 7/10. The impression at the exam was lumbar disc herniation at L5-S1. At that time, her neurosurgeon recommended a new lumbar MRI to further evaluate her increased symptoms. He notes she does not appear able to work at this time and imposed a 10-pound weight limit with no bending or twisting with a sit/stand/lie down option.

The Petitioner was seen again on [redacted] 2019, with continuing complaints of low-back pain and burning in both hips. She described pain in her mid-back when sitting for too long with intermittent pain in her cervical spine. At the time of the follow-up visit, her pain level was 6/10. A physical examination was conducted in straight leg raise was negative in the sitting position with palpable spinous process tenderness noted in the lower back L3 through S1. There is lumbar palpable facet tenderness; the cervical spine and the lumbar spine with increased pain upon extension, flexion, right or left lateral rotation. The recent MRI was reviewed and notes secondary changes of degenerative disc disease at L5-S1. Grade 1 anterolisthesis of L5 on S1. Bilateral L5 spondylosis. Mild osteoarthritis was also reported at L4-L5 and L5-S1. The impression was spinal stenosis, lumbar region with neurogenic claudication, anterolisthesis, and spondylolisthesis of the lumbar region.

The Petitioner was seen by her neurosurgeon on [redacted] 2019, with complaints of constant sharp, heavy, achy, stabbing and dull pain of her cervical and lumbar spine with burning and numbness of the left side of her mid-back. The pain was 6/10 on the pain scale. The pain is reported to become worse with increased activity and movements. This examination was after the x-ray lumbar spine flexion/extension results were completed, and the impression by the doctor was spinal stenosis, lumbar region with neurogenic claudication, spondylolisthesis of lumbar region, Anterolisthesis, lumbar disc herniation L5-S1, lumbar disc herniation with radiculopathy, and cervical neck pain with evidence of disc disease. The plan determined after the visit was that Petitioner has completed several conservative treatments with only minimal relief; no surgery was recommended at that time and that she complete further MRIs and possibly consider of injections once those are completed.

Petitioner was seen on [redacted] 2019, with pain complaints similar to previous visits with the pain level of 8/10 reported. The diagnostic imaging was reviewed by the doctor and noted cervical neck pain with evidence of disc disease and spinal stenosis, lumbar region with neurogenic claudication. A CT was performed approximately seven days later, which noted no acute fracture or subluxation of the cervical spine with mild lower cervical degenerative disc disease. In addition, an open MRI was performed on [redacted] 2018, of the lumbar spine with a comparison to an earlier MRI at that time the notes indicate that at L5-S1 there was a small-to-moderate focal posterior disc herniation which is persistent and has progressed laterally towards the neural foreman, and extends into the neural foreman causing bilateral neural foreman rotation war on the left, then right. Also, a 2.0 mm anterolisthesis at L5-S1 was seen for the first time. The doctor recommended that Petitioner undergo injections with the pain clinic.

In consideration of the *de minimis* standard necessary to establish a severe impairment under Step 2, the foregoing medical evidence is sufficient to establish that Petitioner suffers from severe impairments that have lasted or are expected to last for a continuous period of not less than 90 days. Therefore, Petitioner has satisfied the requirements under Step 2, and the analysis will proceed to Step 3.

Step 3

Step 3 of the sequential analysis of a disability claim requires a determination if the individual's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. 20 CFR 416.920(a)(4)(iii). If an individual's impairment, or combination of impairments, is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 416.909), the individual is disabled. If not, the analysis proceeds to the next step.

Based on the medical evidence presented in this case, listing 1.04 Disorders of the spine was considered. The medical evidence presented does **not** show that Petitioner's impairments meet or equal the required level of severity of any of the listings in Appendix 1 to be considered as disabling without further consideration. Therefore, Petitioner is not disabled under Step 3; and the analysis continues to Step 4.

Residual Functional Capacity

If an individual's impairment does not meet or equal a listed impairment under Step 3, before proceeding to Steps 4 and 5, the individual's residual functional capacity (RFC) is assessed. 20 CFR 416.920(a)(4); 20 CFR 416.945. RFC is the most an individual can do, based on all relevant evidence, despite the limitations from the impairment(s), including those that are not severe, and takes into consideration an individual's ability to meet the physical, mental, sensory and other requirements of work. 20 CFR 416.945(a)(1), (4); 20 CFR 416.945(e).

RFC is assessed based on all relevant medical and other evidence such as statements provided by medical sources, whether or not they are addressed on formal medical examinations, and descriptions and observations of the limitations from impairment(s) provided by the individual or other persons. 20 CFR 416.945(a)(3). *This includes consideration of (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicant takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3).* The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2).

Limitations can be exertional, nonexertional, or a combination of both. 20 CFR 416.969a. If individual's impairments and related symptoms, such as pain, affect only the ability to meet the strength demands of jobs (i.e., sitting, standing, walking, lifting, carrying, pushing, and pulling), the individual is considered to have only exertional limitations. 20 CFR 416.969a(b).

The exertional requirements, or physical demands, of work in the national economy are classified as sedentary, light, medium, heavy, and very heavy. 20 CFR 416.967; 20 CFR 416.969a(a). Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools and occasionally walking and standing. 20 CFR 416.967(a). Light work involves lifting no

more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds; even though the weight lifted may be very little, a job is in the light category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. 20 CFR 416.967(b). Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 20 CFR 416.967(c). Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. 20 CFR 416.967(d). Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. 20 CFR 416.967(e).

If an individual has limitations or restrictions that affect the ability to meet demands of jobs **other than** strength, or exertional, demands, the individual is considered to have only nonexertional limitations or restrictions. 20 CFR 416.969a(a) and (c). Examples of non-exertional limitations or restrictions include difficulty functioning due to nervousness, anxiousness, or depression; difficulty maintaining attention or concentration; difficulty understanding or remembering detailed instructions; difficulty in seeing or hearing; difficulty tolerating some physical feature(s) of certain work settings (i.e., unable to tolerate dust or fumes); or difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching. 20 CFR 416.969a(c)(1)(i) – (vi).

In this case, Petitioner alleges both exertional and nonexertional limitations due to her medical condition. Petitioner testified that she could stand for 10 minutes and then had to sit from 20 to 30 minutes to recover due to pain. The Petitioner testified that she could sit for an hour and could walk a half block. The Petitioner could not perform a squat or touch her toes and could not bend easily at the waist especially side to side. The Petitioner notes that she experiences pain in her left leg due to back pain and can lift no more than 10 pounds and is restricted by her neurosurgeon to this weight restriction. She does need to lie down after some activities due to pain. Petitioner's neurosurgeon who completed the DHS 49 based on her testing also restricted Petitioner's ability to use her feet and legs to operate foot controls with no repetitive motion.

A two-step process is applied in evaluating an individual's symptoms: (1) whether the individual has a medically determinable impairment that could reasonably be expected to produce the individual's alleged symptoms and (2) whether the individual's statement about the intensity, persistence and limiting effects of symptoms are consistent with the objective medical evidence and other evidence on the record from the individual, medical sources and nonmedical sources. SSR 16-3p.

With respect to Petitioner's exertional limitations, it is found based on a review of the entire record that Petitioner lacks the physical capacity to perform sedentary work as defined by 20 CFR 416.967(a).

Petitioner's RFC is considered at both Steps 4 and 5. 20 CFR 416.920(a)(4), (f) and (g).

Step 4

Step 4 in analyzing a disability claim requires an assessment of Petitioner's RFC and past relevant employment. 20 CFR 416.920(a)(4)(iv). Past relevant work is work that has been performed by Petitioner (as actually performed by Petitioner or as generally performed in the national economy) within the past 15 years that was SGA and that lasted long enough for the individual to learn the position. 20 CFR 416.960(b)(1) and (2). An individual who has the RFC to meet the physical and mental demands of work done in the past is not disabled. *Id*.; 20 CFR 416.960(b)(3); 20 CFR 416.920. Vocational factors of age, education, and work experience, and whether the past relevant employment exists in significant numbers in the national economy are **not** considered. 20 CFR 416.960(b)(3).

Petitioner's work history in the 15 years prior to the application consists of working as a Certified Nurse's Assistant, a Convenience Store Clerk/Cashier, a cashier for [redacted] a Home Health Care Provider, and working at [redacted] taking orders and stocking supplies.

Based on the RFC analysis above, as well as the 10-pound weight restriction for lifting and carrying as well as her limitations with standing, sitting and necessity to lie down from time to time, Petitioner's exertional RFC limits her to less than sedentary work activities. As such, Petitioner is incapable of performing past relevant work.

Because Petitioner is unable to perform past relevant work, Petitioner cannot be found disabled, or not disabled, at Step 4, and the assessment continues

Step 5

If an individual is incapable of performing past relevant work, Step 5 requires an assessment of the individual's RFC and age, education, and work experience to determine whether an adjustment to other work can be made. 20 CFR 416.920(a)(4)(v); 20 CFR 416.920(c). If the individual can adjust to other work, then there is no disability; if the individual cannot adjust to other work, then there is a disability. 20 CFR 416.920(a)(4)(v).

At this point in the analysis, the burden shifts from Petitioner to the Department to present proof that Petitioner has the RFC to obtain and maintain substantial gainful employment. 20 CFR 416.960(c)(2); *Richardson v Sec of Health and Human Services*, 735 F2d 962, 964 (CA 6, 1984). While a vocational expert is not required, a finding supported by substantial evidence that the individual has the vocational qualifications to perform specific jobs is needed to meet the burden. *O'Banner v Sec of Health and Human Services,* 587 F2d 321, 323 (CA 6, 1978).

When the impairment(s) and related symptoms, such as pain, only affect the ability to perform the exertional aspects of work-related activities, Medical-Vocational guidelines found at 20 CFR Subpart P, Appendix 2, may be used to satisfy the burden of proving that the individual can perform specific jobs in the national economy. *Heckler v*

Campbell, 461 US 458, 467 (1983); *Kirk v Secretary*, 667 F2d 524, 529 (CA 6, 1981) *cert den* 461 US 957 (1983).

In this case, Petitioner was [redacted] years old at the time of application and [redacted] years old at the time of hearing, and thus, considered to be a younger individual (age 45-49) for purposes of Appendix 2. She is a high school graduate with one and a half years of college with a history of work experience performing unskilled light work. As discussed above, Petitioner does not maintain the exertional RFC for work activities on a regular and continuing basis to meet the physical demands to perform sedentary work activities.

In this case, the Medical-Vocational Guidelines, Appendix 2, do not support a finding that Petitioner is not disabled based on her exertional limitations. The Department has failed to counter with evidence of significant numbers of jobs in the national economy which Petitioner could perform despite his limitations. Therefore, the Department has failed to establish that, based on his RFC and age, education, and work experience, Petitioner can adjust to other work. Therefore, Petitioner is disabled at Step 5.

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, finds Petitioner disabled for purposes of the SDA benefit program.

DECISION AND ORDER

Accordingly, the Department's determination is **REVERSED**.

THE DEPARTMENT IS ORDERED TO INITIATE THE FOLLOWING, IN ACCORDANCE WITH DEPARTMENT POLICY AND CONSISTENT WITH THIS HEARING DECISION, WITHIN 10 DAYS OF THE DATE THE ORDER WAS ISSUED:

1. Re-register and process Petitioner's February 22, 2019, SDA application to determine if all the other non-medical criteria are satisfied and notify Petitioner of its determination;

2. Supplement Petitioner for lost benefits, if any, that Petitioner was entitled to receive if otherwise eligible and qualified;

3. Review Petitioner's continued eligibility in October 2019.

LMF/jaf

Lynn M. Ferris
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

DHHS (via electronic mail)

Garilee Janofski
MDHHS-[redacted]Hearings
BSC2
L Karadsheh

Petitioner (via first class mail)

[redacted]
[redacted]
[redacted] MI [redacted]